STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD RIDGE ASSISTED LIVING	17650 GENERATIONS DRIVE SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00093337 Complaint IN00093337 Substantiated, State Residential findings related to the allegation are cited at: R0154 and R 0273 Survey dates: July 20, 21 and 22, 2011 Facility number: 001148 Provider number: 001148 AIM number: N/A Survey Team: Sandra Haws, RN TC Toni Krakowski, RN Vicki Manuwal, RN Bobbi Costigan, RN Census Bed Type: Residential: 56 Total: 56 Census by payor type: Other: 56 Total: 56 Residential sample: 7 Supplemental sample: 10	R0000	The preparation and execution of this plan of correction does not constitute an admission or agreement by Wood Ridge Assisted Living of the facts alleged or the conclusion set forth in this statement of deficiencies. Correction and specific corrective actions are prepared and/or executed in compliance with state rules.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These State Residential findings are cited in accordance with 410 IAC 16.2. Quality review completed on July 27, 2011 by Bev Faulkner, RN			
R0144	(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on interviews and observations, the facility failed to ensure the environment was clean and in good repair related to the chapel having 7 chairs with soiled stained seats and a rough finish, a large gaping hole in the wall that once contained a large cooling unit exposing the outside and allowing the outside heat to enter the room. The facility failed to ensure the 2nd floor was free from urine odors and failed to ensure 3 resident rooms did not have soiled toilets (Residents: # 50, #2, and # 27) and 2 residents (Resident #50 and #39) did not have wastebaskets with urine soaked depends for 4 of 4 residents in a supplemental sample of 10. Findings include:	R0144	Replacement chairs for the chapel have been ordered.The air conditioning unit had been removed on 7/21/11 in order for the maintenance supervisor to clean and repair it. A covering for the hole in the wall was provided. After the unit was cleaned and repaired, it was placed back in the space it occupied, after that space was cleaned.The soiled attends were removed. The toilet seats and bathrooms were cleaned.Housekeeping and C.N.A. assignment sheets are updated to include checking all resident apartments each shift to ensure trash, including incontinent briefs, is emptied and toilets and bathrooms are cleaned if needed.When a resident is initiallly assessed by Health Services Supervisor or designee, housekeeping	08/22/2011

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	During a tour of the 2nd floor on 7/20/11 at 11:00 a.m., accompanied by QMA # 3, a strong foul urine odor was present. Upon entrance into Resident #39's room, a very strong urine odor was present in the room. The strong odor was detected prior to entering the room. The resident's wastebasket was observed to be full of urine soaked briefs. The odor on the 2nd floor continued on 7/20/11 at 12:00 p.m., 1:00 p.m., 2:00 p.m., 3:00 p.m. and 4:00 p.m. The strong urine odor was present on the 2nd floor on 7/21/11 at 9:00 a.m., 10:00 a.m. and 11:00 a.m., 12:00 p.m. 1:00 p.m., 2:00 p.m. 3:00 p.m. 4:00 p.m. and 5:00 p.m. On 7/22/11, a strong urine odor was present on the 2nd floor at 8:30 a.m., 9:00 a.m., 10:00 a.m., 11:00 a.m. 12:00 p.m., 1:00 p.m., 2:00 p.m. and 3:00 p.m. During a tour of the facility's 2nd floor,on 7/21/11 at 11:00 a.m., an observation was made of the facility's chapel area. The chapel contained 7 wooden straight back chairs with cloth seats. The finish on the wood was worn off exposing bare wood on the arms of the chairs. The cloth seats were a rose color with dark soiled stains on all the seats. An observation at that time was made of a large opening in the wall that once contained a cooling unit. The opening had a metal vent which allowed the hot outside air to enter the		abilities/incontinence issues will be reviewed to determine whether or not the resident requires housekeeping services each shift, daily, every other day, or weekly. This will be re-assessed during quarterly service plan reviews or when there is a change in condition.The Maintenance Supervisor, Administrator, Health Services Supervisor or designee will monitor daily during rounds on a continuous basis to ensure apartments are clean. Our criteria is that rounds are made by the designees on a daily basis to ensure compliance.	

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	room and 2nd floor. According WSBT, a local weather alert channel on 7/21/11 at 12:45 p.m., the outside temperature was stated to be 97 degrees with a heat index of 105- 115 degrees. The large opening was observed to have a ledge on the inside containing straw pieces, dirt debris and pieces of grayish colored droppings and feathers. The chapel had a strong smell of cigarette smoke. A bottle of Fabreez (deodorizer) was observed being removed by the Director of Nursing. During an interview with the Director of Nursing on 7/21/11 at 11:00 a.m. regarding the chapel, she indicated the air conditioning unit was removed to use in a resident's room. She further indicated the facility is a non-smoking facility. During an interview with Resident #50, who was observed to be wheelchair bound, on 7/21/11 at 11: 30 a.m., she was concerned about the facility housekeeping. The resident went into her bathroom and pointed to her wastebasket. The wastebasket was full of urine soaked briefs. From the top of the 18 inch deep wastebasket the briefs were stacked 12 inches over the top. The resident indicated many times they are stacked past the sink because housekeeping may come in only once a week to empty the trash. A wastebasket was observed next to the resident's bed. Soiled briefs were			

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	observed to fill the wastebasket half full. The resident's toilet was observed to have brown feces smeared on the toilet lid. The resident's carpet was soiled with paper and dirt debris. The bathroom floor tile was observed to be discolored with dirt. A dry soiled wash cloth was observed on the floor next to the toilet. The resident's room was located on the 2nd floor. During a tour of the facility on 7/21/11 at 3:20 p.m., accompanied by Maintenance Staff # 2, an observation was made of Resident #2's bathroom. The resident's toilet was observed to be soiled with dark black and gold streaks all along the inside of the toilet bowl. A tour of Resident #27's room on 7/21/11 at 3:30 p.m., an observation was made of his toilet bowl soiled with black streaks all around the inside of the toilet bowl. During an interview with the Maintenance personnel regarding the strong urine odors on the 2nd floor on 7/21/11 at 3:30 p.m., he had no comment. During an interview with the Administrator on 7/21/11 at 6:00 p.m. regarding the resident's wastebasket overflowing with urine soaked depends ,the resident's soiled toilets, and urine odor on the 2nd floor, she indicated the housekeeping staff clean only once			

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	weekly.			
R0148	(e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on interview and observation, the facility failed to ensure their heating and ventilating system was inspected at least yearly. This deficient practice has the potential to affect all 56 of 56 residents living in the facility. Findings include: During a tour of the 2nd floor on 7/20/11 at 11:15 accompanied by QMA # 3, the 2nd floor temperature felt very warm. The	R0148	The heating and ventilation systems have been inspected.The air conditioning on the second floor had been working properly until the extreme heat conditions which occurred on 7/20/11. The company that services the air conditioning for this community was contacted on 7/20/2011 regarding the warm conditions in the building. The company arrived on 7/21/2011. The service technician inspected the unit, cleaned it, filled with freon and at the end of the day it	08/02/2011

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	thermometer on the wall was observed to read 80 degrees. QMA # 3 agreed it was warm. The floor remained warm all day. The thermometer on the 2nd floor at 2:25 p.m. was observed to read 84 degrees. During an interview with the Maintenance staff # 2 on 7/20/11 at 12:10 p.m. regarding the warm temperature on the 2nd floor, he indicated some of the residents like their windows or balcony doors open. During the tour of multiple resident rooms on the 2nd floor on 7/20/11, no doors or windows were observed to be open. During another tour of the 2nd floor on 7/21/11 at 9:00 a.m. and throughout the day, the 2nd floor temperature felt very warm. An observation was made of the thermostat at 9:00 a.m., reading 70 degrees. The temperature outside on 7/21/11 was 97 degrees according to WSBT, a local weather station. Throughout the entire day the thermostat stayed at 70 degrees even though the temperature of the 2nd floor felt much hotter later in the day at 3:00 p.m. During an interview with the Maintenance staff # 2 on 7/21/at 3:50 p.m., regarding the thermostat staying at 70 degrees all day even though the temperature of the floor felt warmer, he indicated he wasn't sure why it wasn't working properly.		was working adequately.A new air conditioning unit was installed on 8/2/2011. The service technician inspected the ventilating system on 8/2/2011.The preventive maintenance form for recording air conditioning and heating inspections includes an area for yearly inspection of the heating and ventilating system.The Maintenance Supervisor is responsible to monitor the checklist monthly to ensure prompt inspection of the systems. The Maintenance Supervisor will review the form with the Administrator monthly.	

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	During an interview with the Administrator on 7/21/11 at 4:55 p.m. regarding the warm temperature on the 2nd floor and if the facility's ventilation system had been inspected this past year. The Administrator indicated the heating and ventilation system had never been checked.			
R0154	(k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure the kitchen area and equipment was clean and well maintained. This deficient practice had the potential to affect 56 of 56 residents who ate and resided in the facility. Findings include: During observation of the kitchen on 7/20/11 at 11:00 A.M., while accompanied by the Dietary Supervisor, the following was observed:	R0154	All areas noted to be in need of attention have been addressed by cleaning, saniftizing and/or discarding and removing from the kitchen. Color coded "day dots" are utilized for monitoring open and discard dates.The Registered Dietician will present an inservice 8/9/11 to review sanitation including proper storage of food items, serving items and utensils, and labeling and dating items. After the inservice, staff will understand and demonstrate proper safety and sanitation standards.Cleaning schedules have been revised to include a	08/22/2011

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	The kitchen handwashing sink was laden with a build-up of white scaly matter, the large stove (right) oven was laden with black, charred build-up (left side oven was not in operating order), two cream colored foot stools (one under the convection oven and one under the two compartment sink) were heavily laden with a greasy gray/black soil, dime sized of black fuzzy growth, the fan and coil (on the inside refrigeration unit) and a sprinkler-head in the walk-in cooler were laden with a build-up of a white or black fuzzy substance, the outer finish of two pots and two large frying pans had a baked-on dark brown/black charred coating, the louvered ceiling vent over the food (prep) preparation area lacked a screen, the sprinkler-head over the food prep table was laden with a build-up of dust, the ceiling vent in the dishwashing area had rust deposits on it, the kitchen's two compartment sink had a build-up of white, scaly matter, the floor vent beneath that sink had large rust deposits and the cove molding and floor had a build-up of brown/gray loose dirt, a ceiling vent above the three compartment dishwashing sink had condensation which was observed dripping onto a rack of clean glasses, a large, rectangular, uncovered opening in the ceiling, immediately over the commercial dishwasher unit, had an extremely heavy build-up of black, furry,		more detailed checklist to ensure all areas of sanitation are covered.Dining Services Manager will attend a Serve Safe Training The Dining Services Manager will review cleaning schedules on a daily basis to ensure they are being followed.The Dining Services Manager will review the cleaning schedules at least weekly with the Administrator to ensure compliance and follow through.The Dining Services Manager, cooks, Administrator are responsible to monitor to ensure compliance.	

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	matter clinging to the interior walls of the shaft, the floor and cove molding immediately beneath the dishwasher unit had a white scaly build-up, the white pipe attached to the garbage disposal had a black/brown substance clinging to the pipe, the ice machine drain had reddish-brown slime on its circumference, the light gray floor grout was black throughout most of the kitchen, the cove molding and floor underneath and behind the convection oven and stove was covered with a heavy build-up of dark brown/black dirt, a large, beachball sized crater and several baseball sized craters were chipped out of the walk-in cooler concrete floor. Review of the facility cleaning schedule for the kitchen indicated the sinks, and shelves were to be cleaned daily. The inside of the ovens were to be cleaned bi-weekly. The ice machine and coolers were to be cleaned weekly and checked for outdated foods. All major appliances were to cleaned under weekly. The July schedule indicated all of the above had been completed through July 20, 1011. During an interview with the Dietary Manager on 7/20/11 at 11:20 A.M., he indicated he had only been employed at the facility for five weeks. He further indicated the kitchen was in need of a			

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	deep-cleaning. He was not sure what the two cream-colored foot stools were used for or why they were kept in the food preparation area. This state rule substantiates Complaint IN00093337.			
R0179	(c) Each facility shall have an adequate air conditioning system, as governed by applicable rules of the fire prevention and building safety commission (675 IAC). The air conditioning system shall be maintained in normal operating condition and utilized as necessary to provide comfortable temperatures in all resident and public areas. Based on interviews and observations, the facility failed to maintain a comfortable temperature for residents living on the 2nd floor of the facility for 3 of 3 residents in a supplemental sample of 10 and had the potential to affect all 36 residents that live on the 2nd floor of the facility. Residents: #35, # 45 and # 36. Findings include:	R0179	Until the extreme heat conditions that occurred on 7/20/11 the air conditioning unit on the second floor was working properly.The company that services the air conditioning for this facility was contacted on 7/20/2011 regarding the warm conditions in the second floor hallways. The company technician arrived on 7/21/11 to service the unit. The technician inspected the unit, cleaned the fan, filled the unit with freon and it was working	08/02/2011

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	During a tour of the 2nd floor on 7/20/11 at 11:15 a.m., accompanied by QMA # 3, the 2nd floor temperature felt very warm. The thermometer on the wall was observed to read 80 degrees. QMA # 3 agreed it was warm. The floor remained warm all day. The thermometer on the 2nd floor at 2:25 p.m., was observed to read 84 degrees. During an interview with the Maintenance staff # 2 on 7/20/11 at 12:10 p.m. regarding the warm temperature on the 2nd floor, he indicated some of the residents like their windows or balcony doors open. During tour of multiple resident rooms on the 2nd floor 7/20/11, no doors or windows were observed open. During another tour of the 2nd floor on 7/21/11 at 9:00 a.m. and throughout the day on the 2nd floor daily, the 2nd floor temperature felt very warm. An observation was made of the thermostat at 9:00 a.m., reading 70 degrees. The temperature outside on 7/21/11 was 97 degrees according to WSBT, a local weather station. Throughout the entire day the thermostat stayed at 70 degrees even though the temperature of the 2nd floor felt much hotter later in the day at 3:00 p.m. During an interview with the Maintenance staff # 2 on 7/21/at 3:50 p.m.		adequately at the end of the service call.A new unit was installed on 8/2/2011. The second floor temperature remains at a comfortable level.All air conditioning units in all apartments have been working properly, and were in working order on the days the hallways were extremely warm.Residents and staff members are aware to report any air conditioning unit that may not be working properly.The Maintenance Supervisor checks apartments and hallways daily to ensure all units are in good working order.Administrator conducts daily rounds and will monitor temperatures in the hallways and apartments.The Maintenance Supervisor will meet at least weekly to discuss any problems or concerns with the Administrator.	

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	regarding the thermostat staying at 70 degrees all day even though the temperature of the floor felt warmer, he indicated he wasn't sure why it wasn't working properly. On 7/21/11 at 3:00 p.m., the 1st floor temperature felt much cooler. The thermostat on the 1st floor wall was observed to read 70, same as reading the 2nd floor although the 2nd floor felt much warmer. The discrepancy was brought to the Maintenance staff # 2's attention with no comment other than he indicated the 2nds floor thermostat may not be working properly. During an interview with Resident #35 who resides on the 2nd floor on 7/21/11 at 3:10 p.m. regarding the temperature of the floor, she indicated it was very warm on the floor and she needed to go into her room to cool off. The sitting area where residents watch television was very warm, a fan was observed running and blowing warm air towards that direction. During an interview with Resident #45 on 7/21/11 at 3:30 p.m., who was observed sitting in the television area and resides on the 2nd floor, he stated "It's way too warm up here, it's not comfortable at all." During an interview with Resident #36			

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	who resides on the 2nd floor, on 7/21/11 4:45 p.m. regarding the temperature on the 2nd floor, she indicated it was very warm. Resident #36's requested her room air conditioner be observed. The air conditioner was observed to be at the highest cooling and fan selection. The room did not feel cold with the air conditioner set at the highest speed and coldest selection. Resident # 36 indicated she gets very hot at night and then feels cold in the morning. A wall thermostat in the resident's room was not observed.			
R0241	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure medications were given according to physician orders regarding correct sliding scale insulin coverage for 3 of 3 residents (Residents # 16, 23, 46) reviewed with sliding scale coverage and failed to administer oral medications as ordered for 2 of 7 residents	R0241	The physician's orders for residents #16, #23, #46, and #7 have been reviewed, clarified and if necessary corrected to indicate proper sliding scale and other tests/procedures required.Other residents who had the potential to be affected were identified through a facility audit.The consultant pharmacist will	08/15/2011

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		A. BUILDING 00 B. WING	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD RIDGE ASSISTED LIVING	17650 GENERATIONS DRIVE SOUTH BEND, IN46635

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	(Resident # 7, 16) reviewed with medications and failed to follow blood pressure parameters for 1 of 6 residents (Resident # 16) reviewed for hypertension and failed to follow call orders for 1 of 3 residents (Resident # 23) reviewed for call orders and failed to ensure Accu Checks (finger stick blood sugar test) were done as ordered for 3 of 3 residents (Resident # 16, 23, 46) reviewed with Accu Checks in a sample of 7. Findings include: 1. The clinical record for Resident # 46 reviewed on 7/20/11 at 11:00 A.M., indicated diagnoses of, but not limited: diabetes mellitus, hypertension, and hyperthyroidism. The July 2011, "Physician's Orders", indicated, "...Accu Checks before meals and at HS (bedtime)...5/4/11...Novolin R...sliding scale...200-250=4 units; 251-300=6 units; 301-350=8 units; 351-420=10 units...5/4/11..." Review of the May 2011, "Medication Record", indicated Accu Checks were only done at 7:30 A.M. and HS. It further indicated incorrect sliding scale coverage for the following: 5/7/11 HS Accu Check - 279 given 5		conduct an inservice on 8/15/11 to review diabetic care including accu checks, sliding scales and insulin administration.The Health Services Supervisor or designee will review diabetic records daily to ensure proper procedures for diabetic residents are followed.The Health Services Supervisor or designee will review medication administration records daily to ensure physician orders for medications have been followed. This will be done on a continuous basis.The Health Services Supervisor or designee will notify physicians daily, if need, regarding residents who's blood sugars are not within sliding scale guidelines, and who's blood pressures are not within noted parameters.The Health Services Supervisor, Medical Records Designee, Administrator are responsible to monitor to ensure compliance.	

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	units. The next available Accu Check was 197 on 5/8/11 at 7:30 A.M. Review of the June 2011, "Medication Record", indicated Accu Checks were only done at 7:30 A.M. and HS. It further indicated incorrect sliding scale coverage and omission of Accu Check testing for the following: 6/6/11 HS Accu Check - 221 given 6 units. The next available Accu Check was 85 on 6/7/11 at 7:30 A.M. 6/22/11 Accu Check at HS not completed. Review of the July 1st through July 19th, 2011, "Medication Record", indicated Accu Checks were only done at 7:30 A.M. and HS. It further indicated incorrect sliding scale coverage for the following: 7/16/11 HS Accu Check - 232 given 0 units. The next available Accu Check was 98 on 7/17/11 at 7:30 A.M. A "Physician's Telephone Orders", dated 5/4/11, indicated, "...Accu Check A.C. (before meals)..." Review of a "Consultation Report", dated 5/1/11 through 5/31/11, signed by the physician on 6/6/11, indicated,			

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	"...Recommend BS (blood sugar) QID (four times daily) ac & hs x (times) 7 days to evaluate all post-prandial (after eating) control then BID (twice daily) rotating before breakfast and dinner with before lunch and hs...Physician's Responses...I accept the recommendation(s) above..." Review of a (Name) lab report, dated 8/2/10, indicated, "...Hgb A1C (blood test to determine an average of blood sugars for the prior three months)...13.1 (H) (high)...Normal 4.2-5.8; Good Control 5.5-6.8; Fair Control 6.9-7.6; Poor Control > (greater than) 7.6..." An "Initial Evaluation/Service Plan for Residential Care", dated 1/18/11, updated 4/19/11 & 7/19/11, indicated, "...Medications...Requires staff to order, store and dispense medication(s)...Extended Service. Requires staff to check CBG's (blood sugars) more than daily..." The clinical record lacked documentation of the resident's condition and how she felt after receiving the incorrect insulin coverage. During interview on 7/21/11 at 2:55 P.M., LPN # 1 indicated the doctor didn't totally clarify how many times he really wanted Accu Checks so they are just doing it			

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	twice daily. She further indicated she was unsure if Resident # 46 had a more current Hgb A1C result. 2. The clinical record for Resident # 16 reviewed on 7/20/11 at 3:55 P.M., indicated diagnoses of, but not limited: diabetes mellitus, hypertension, and atrial fibrillation. The July 2011, "Physician's Orders", indicated, "...Digoxin 125 mcg (micrograms)...give 1 tablet orally every other day on odd days...Verapamil ER 240 mg (milligrams)...give 1 tablet orally once a day - Hold for SBP (systolic blood pressure) < (less than) 130...Accu Checks daily...Novolin R...sliding scale...151-200=2 units; 201-250=4 units; 251-300=6 units; > (greater than) 350=10 units & call MD..." Review of the April 2011, "Medication Record", indicated incorrect sliding scale coverage or lack of Accu Check monitoring for the following: 4/5/11 Accu Check - 192 4/9/11 Accu Check not done 4/10/11 Accu Check not done 4/15/11 Accu Check - 160 4/19/11 Accu Check - 167 4/20/11 Accu Check - 151 4/22/11 Accu Check - 210			

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	4/23/11 Accu Check not done 4/25/11 Accu Check - 163 4/26/11 Accu Check - 216 4/27/11 Accu Check - 193 4/28/11 Accu Check - 178 4/29/11 Accu Check - 184 4/30/11 Accu Check - 177 The clinical record lacked documentation of sliding scale coverage for 11 days in April when coverage was indicated. The April 2011, "Medication Record", lacked documentation of blood pressure monitoring for 25 of 30 days. Review of the May 2011, "Medication Record", indicated incorrect sliding scale coverage for the following: 5/2/11 Accu Check - 154 5/4/11 Accu Check - 187 5/6/11 Accu Check - 170 5/12/11 Accu Check - 160 5/16/11 Accu Check - 152 5/17/11 Accu Check - 181 5/18/11 Accu Check - 165 5/22/11 Accu Check - 170 5/24/11 Accu Check - 165 5/28/11 Accu Check - 167 The clinical record lacked documentation of sliding scale coverage for 10 days in May when coverage was indicated.			

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The May 2011, "Medication Record", lacked documentation of blood pressure monitoring for 26 of 30 days and further indicated the following 3 blood pressure readings that fell below the parameters but Verapamil was still given:

5/7/11 - 112/86
5/14/11 - 128/82
5/21/11 - 118/84

Review of the June 2011, "Medication Record", indicated incorrect sliding scale coverage for the following:

6/10/11 Accu Check - 153
6/11/11 Accu Check - 189
6/23/11 Accu Check - 183
6/28/11 Accu Check - 200
6/30/11 Accu Check - 178

The clinical record lacked documentation of sliding scale coverage for 5 days in June when coverage was indicated.

The June 2011, "Medication Record", lacked documentation of blood pressure monitoring for 26 of 30 days and further indicated the following 2 blood pressure readings that fell below the parameters but Verapamil was still given:

6/4/11 - 106/87

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	6/11/11 - 128/86 Review of the June 2011, "Medication Record", also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on 6/5/11 and 6/19/11. Review of the July 2011, "Medication Record", indicated incorrect sliding scale coverage for the following: 7/6/11 Accu Check - 204 7/13/11 Accu Check - 191 The clinical record lacked documentation of sliding scale coverage for 2 days from July 1st through July 20th when coverage was indicated. The July 1st through July 20th, 2011, "Medication Record", lacked documentation of blood pressure monitoring for 17 of 20 days and further indicated the following 2 blood pressure readings that fell below the parameters but Verapamil was still given: 7/9/11 - 100/50 7/16/11 - 120/62 Review of an "Initial Evaluation/Service Plan for Residential Care", dated 3/30/11, updated 6/29/11, indicated,			

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"...Medications...Requires staff to order, store and dispense medication(s)...Requires staff to check CBG's (capillary blood glucose) daily...

A (Name) lab report, dated 3/26/10, indicated, "...Digoxin 1.0...range 0.9-2.0..."

During interview on 7/21/11 at 2:50 P.M., LPN # 1 indicated Resident #16 refuses sliding scale coverage and it should be charted on the MAR (Medication Administration Record). She further indicated the facility typically faxes the doctor at the end of the month to inform him/her of the refusal however the clinical record lacked documentation.

On 7/22/11 at 10:05 A.M., LPN # 1 indicated the doctor ordered blood pressure and pulses weekly and also ordered daily blood pressures so unsure what the order should be.

LPN # 1 on 7/22/11 at 12:35 P.M., indicated the facility received clarification from the doctor and the order is for daily blood pressure monitoring with parameters to hold Verapamil for systolic blood pressure less than 130.

During interview with LPN # 1 on 7/22/11 at 4:40 P.M., she indicated

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	3/26/10 was the last Digoxin level for Resident # 16. She further indicated the physician's office stated the resident was supposed to have levels drawn twice a year. 3. The clinical record for Resident # 23 reviewed on 7/21/11 at 10:55 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and hypothyroidism. The July 2011, "Physician's Orders", indicated, "...Accu Checks 4 X daily...Novolog...sliding scale before meals and at bedtime...141-160=1 units (sic); 161-180=2 units; 181-200=3 units; 201-220=4 units; 221-240=5 units; 241-260=6 units; 261-280=7 units; 281-300=8 units; 301-320=9 units; 321-340=10 units; 341-360=11 units; 361-380=12 units; 381-400=13 units; 401-420=14 units; 421-440=15 units; 441-460=16 units; 461-480=17 units; 481-500=18 units; < (less than) 100 or > (greater than) 500 call MD..." Review of the April 2011, "Medication Record", indicated incorrect sliding scale coverage or lack of Accu Check monitoring for the following: 4/1/11 4:30 P.M. - 182 given 2 units 4/7/11 HS (bedtime) - 143 given 0 units			

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	4/10/11 4:30 P.M. - 142 given 0 units 4/11/11 HS (bedtime) - 143 given 0 units 4/12/11 11:30 A.M. - no Accu Check done 4/25/11 4:30 P.M. - 262 given 6 units 4/26/11 11:30 A.M. - 199 given 2 units The clinical record indicated a total of 7 incorrect sliding scale coverages during the month of April 2011. The April 2011, "Medication Record" further indicated the following Accu Check results that fell within call parameters: 4/3/11 7:00 A.M. - 92 4/4/11 7:00 A.M. - 98 4/5/11 7:00 A.M. - 93 4/5/11 11:30 A.M. - 92 4/5/11 4:30 P.M. - 90 4/14/11 7:00 A.M. - 79 4/19/11 4:30 P.M. - 97 4/28/11 4:30 P.M. -77 4/30/11 7:00 A.M. - 98 During the month of April 2011, the clinical record lacked documentation of physician notification of low blood sugars a total of 9 times. Review of the May 2011, "Medication Record", indicated incorrect sliding scale coverage or lack of Accu Check monitoring for the following:			

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5/1/11 HS - 141 given 0 units
5/3/11 HS - 192 given 4 units
5/6/11 HS - 170 given 3 units
5/9/11 11:30 A.M. - 211 given 6 units
5/11/11 11:30 A.M. - 128 given 8 units.
Next available BS reading 149.
5/15/11 4:30 P.M. - 227 no coverage documented
5/15/11 HS - 199 given 2 units
5/24/11 4:30 P.M. - 150 given 2 units
5/28/11 11:30 A.M. - no Accu Check done

The clinical record indicated a total of 7 incorrect sliding scale coverages and a lack of Accu Check monitoring a total of 2 times during the month of May 2011.

The May 2011, "Medication Record" further indicated the following Accu Check results that fell within call parameters:

5/1/11 11:30 A.M. - 76
5/8/11 7:00 A.M. - 99
5/11/11 7:00 A.M. - 90
5/13/11 7:00 A.M. - 96
5/14/11 4:30 P.M. - 69
5/15/11 7:00 A.M. - 94
5/16/11 7:00 A.M. - 97
5/18/11 7:00 A.M. - 87
5/20/11 7:00 A.M. - 96
5/22/11 7:00 A.M. - 94
5/23/11 7:00 A.M. - 98

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	5/24/11 7:00 A.M. - 97 5/27/11 7:00 A.M. - 94 5/29/11 7:00 A.M. - 97 5/30/11 7:00 A.M. - 85 During the month of May 2011, the clinical record lacked documentation of physician notification of low blood sugars a total of 15 times. Review of the June 2011, "Medication Record", indicated incorrect sliding scale coverage or lack of Accu Check monitoring for the following: 6/1/11 4:30 P.M. - 162 no coverage documented 6/1/11 HS - 161 no coverage documented 6/6/11 11:30 A.M. - 188 given 2 units 6/8/11 HS - 189 given 2 units 6/13/11 HS - 182 given 2 units 6/15/11 4:30 P.M. - 166 no coverage documented 6/26/11 11:30 A.M. - no Accu Check done 6/29/11 HS - no Accu Check done The clinical record indicated a total of 6 incorrect sliding scale coverages and a lack of Accu Check monitoring a total of 2 times during the month of June 2011. The June 2011, "Medication Record" further indicated the following Accu Check results that fell within call			

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	parameters: 6/1/11 7:00 A.M. - 95 6/2/11 7:00 A.M. - 99 6/4/11 7:00 A.M. - 90 6/7/11 7:00 A.M. - 85 6/8/11 7:00 A.M. - 98 6/12/11 7:00 A.M. - 99 6/13/11 7:00 A.M. - 92 6/13/11 4:30 P.M. - 79 6/14/11 4:30 P.M. - 80 6/17/11 7:00 A.M. - 92 6/17/11 4:30 P.M. - 96 6/22/11 7:00 A.M. - 97 6/24/11 4:30 P.M. - 82 6/27/11 7:00 A.M. - 92 6/28/11 7:00 A.M. - 86 During the month of June 2011, the clinical record lacked documentation of physician notification of low blood sugars a total of 15 times. Review of the July 2011, "Medication Record", indicated incorrect sliding scale coverage for the following: 7/2/11 HS - 172 given 3 units 7/13/11 4:30 P.M. - 239 given 0 units 7/16/11 HS - 170 given 3 units The clinical record indicated a total of 3 incorrect sliding scale coverages from July 1st through July 20th, 2011.			

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The July 2011, "Medication Record" further indicated the following Accu Check results that fell within call parameters:

7/3/11 4:30 P.M. - 82
7/5/11 4:30 P.M. - 90
7/7/11 4:30 P.M. - 80
7/16/11 4:30 P.M. - 91

During the month of July 2011, the clinical record lacked documentation of physician notification of low blood sugars a total of 4 times from July 1st through July 20th, 2011.

Review of an "Initial Evaluation/Service Plan for Residential Care", dated 3/29/11, updated 6/28/11, indicated, "...Medications...Requires staff to order, store and dispense medication(s)...Extended Service: Requires staff to check CBG's more than daily...."

Review of a (Name) Lab report, dated 3/19/11, indicated, "...Hemoglobin A1C...normal range 4.0 - 6.0...3/18/11...6.2..."

Interview with LPN # 1 on 7/21/11 at 2:55 P.M., she indicated she is unsure if the blood sugar call orders were followed or

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		A. BUILDING 00 B. WING	07/22/2011

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WOOD RIDGE ASSISTED LIVING	17650 GENERATIONS DRIVE SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	called to the physician when the blood sugar was less than 100. She further indicated one nurse draws up the insulin doses and that dose is not checked by a second nurse to confirm accuracy of the dose. She also indicated it is not a facility policy to check the Medication Administration Records at the end of the month for sliding scale dosing accuracy. The Lippincott Manual of Nursing Practice, Fourth Edition, indicated, "...Normal Fasting Glucose (blood sugar) level - 60-110 mg/dl...normal post prandial (blood sugar 2 hours after meals) - 65-140 mg/dl...The dose of insulin is adjusted to maintain the blood glucose with normal range (65-130 mg/dl)...When insulin requirements are changing rapidly, supplemental injections of regular insulin are given before each meal....NURSING ALERT: There is a narrow margin between the amount of insulin needed to make the blood glucose normal and the amount that will cause hypoglycemia..." The 2010 Nursing Spectrum Drug Handbook, indicated, "...digoxin...drug has narrow therapeutic index, so dosage must be monitored regularly and patient must be monitored for signs and symptoms of toxicity....Tell patient to take drug at same time..."			

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	A facility policy titled, "Communication with Physicians", dated 2006, indicated, "...It is the policy of this facility to keep the residents' physicians informed regarding the residents' condition....The Community will maintain written documentation of notification of the physician(s) of a change in resident condition in the resident record...." Review of a facility policy titled, "Guidelines for Delegation", undated, indicated, "...Through the assessment process, the RN will be able to determine appropriate parameters, for the action to be taken and person(s) to be notified, that are specific and unique to each resident. " 4. Review of Resident # 7's clinical record on 7/20/11 at 12:45 p.m., indicated diagnoses of, but not limited to, senile dementia, altered mental status, and HTN (hypertension). During a record review of the "Physician's Orders," dated 4/01/11 through 4/30/11, the orders for Venlafaxine HCL ER (Effexor) 37.5 mg (milligram) (used for depression) taken once daily by mouth was discontinued on 4/7/11. A new order for Venlafaxine HCL ER 75 mg to be taken once daily by mouth was started on 4/7/11.			

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	During a record review of the "Medication Record" dated 4/8/11, QMA #3 charted that Venlafaxine HCL ER 37.5 mg was given. And again on 4/8/11 LPN #4 charted that Venlafaxine HCL ER 75 mg. Total dose given on 4/8/11 was Venlafaxine HCL ER 112.5 mg. During an interview with LPN #1 on 7/20/11 at 3:00 p.m., she indicated that she was unaware the Venlafaxine HCL ER was given twice on 4/8/11. LPN # 1 indicated that the nurse must have "accidentally" signed the Medication Record twice.			
R0247	(7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to keep the residents' physicians updated regarding errors in medication administration and failed to document those errors in the clinical record for 4 of 7 residents reviewed for medication errors in a sample of 7.	R0247	The physicians for residents #7, #6, #23, and #46 have been notified regarding the sliding scales and insulin administration as well as other medication errors noted.Other residents who had the potential to be affected will be identified through a facility audit of their records.An inservice regarding medication errors	08/15/2011

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	Resident # 7, 16, 23, 46, Findings include: 1. The clinical record for Resident # 46 reviewed on 7/20/11 at 11:00 A.M., indicated diagnoses of, but not limited: diabetes mellitus, hypertension, and hyperthyroidism. The July 2011, "Physician's Orders", indicated, "...Accu Checks before meals and at HS (bedtime)...5/4/11...Novolin R...sliding scale...200-250=4 units; 251-300=6 units; 301-350=8 units; 351-420=10 units...5/4/11..." Review of the May 2011, "Medication Record", indicated incorrect sliding scale coverage on: 5/7/11 at HS - Accu Check 279. Given 5 units but should have received 6 units. The June 2011, "Medication Record", indicated incorrect sliding scale coverage on: 6/6/11 at HS - Accu Check 221. Given 6 units but should have received 4 units. Review of the July 1st through July 19th, 2011, "Medication Record", indicated		report and recording and physician notification will be held 8/15/2011. The Medication Error Policy and Procedure and Medication Error form will be reviewed. Nurses and Q.M.A.s will understand what constitutes a medication error and how to complete the form. The inservice will also review the state rule and these findings so that they increase their understanding of reporting medication errors.The Health Services Supervisor or designee will review the Medication Administration Records daily to ensure proper medication administration, and if errors are noted, that the form was completed properly and the physician was notified.At least twice weekly, the Health Services Supervisor or designee will review the finings with the Administrator. This will be completed on an on-going basis and become part of the routine quality assurance review.The Health Services Supervisor, Medical Records Designee and Administrator are responsible to monitor to ensure compliance.	

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	incorrect sliding scale coverage on: 7/16/11 at HS - Accu Check 232. Given 0 units but should have received 4 units. The clinical record lacked documentation of physician notification. 2. The clinical record for Resident # 16 reviewed on 7/20/11 at 3:55 P.M., indicated diagnoses of, but not limited: diabetes mellitus, hypertension, and atrial fibrillation. The July 2011, "Physician's Orders", indicated, "...Digoxin 125 mcg (micrograms)...give 1 tablet orally every other day on odd days...Verapamil ER 240 mg (milligrams)...give 1 tablet orally once a day - Hold for SBP (systolic blood pressure) < (less than) 130...Accu Checks daily...Novolin R...sliding scale...151-200=2 units; 201-250=4 units; 251-300=6 units; > (greater than) 350=10 units & call MD..." Review of the April 2011, "Medication Record", indicated lack of sliding scale coverage for the following 11 days when coverage was indicated: 4/5/11 Accu Check - 192. Should have received 2 units. 4/9/11 Accu Check not done			

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	4/10/11 Accu Check not done 4/15/11 Accu Check - 160. Should have received 2 units. 4/19/11 Accu Check - 167. Should have received 2 units. 4/20/11 Accu Check - 151. Should have received 2 units. 4/22/11 Accu Check - 210. Should have received 4 units. 4/23/11 Accu Check not done 4/25/11 Accu Check - 163. Should have received 2 units. 4/26/11 Accu Check - 216. Should have received 4 units. 4/27/11 Accu Check - 193. Should have received 2 units. 4/28/11 Accu Check - 178. Should have received 2 units. 4/29/11 Accu Check - 184. Should have received 2 units. 4/30/11 Accu Check - 177. Should have received 2 units. The May 2011, "Medication Record", indicated lack of sliding scale coverage for the following 10 days when coverage was indicated: 5/2/11 Accu Check - 154. Should have received 2 units. 5/4/11 Accu Check - 187. Should have received 2 units. 5/6/11 Accu Check - 170. Should have received 2 units.			

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	5/12/11 Accu Check - 160. Should have received 2 units. 5/16/11 Accu Check - 152. Should have received 2 units. 5/17/11 Accu Check - 181. Should have received 2 units. 5/18/11 Accu Check - 165. Should have received 2 units. 5/22/11 Accu Check - 170. Should have received 2 units. 5/24/11 Accu Check - 165. Should have received 2 units. 5/28/11 Accu Check - 167. Should have received 2 units. The May 2011, "Medication Record", further indicated Verapamil was given on the following 3 days when Resident # 16's blood pressure readings fell below the hold parameters: 5/7/11 - 112/86 5/14/11 - 128/82 5/21/11 - 118/84 Review of the June 2011, "Medication Record", indicated lack of sliding scale coverage for the following 5 days when coverage was indicated: 6/10/11 Accu Check - 153. Should have received 2 units. 6/11/11 Accu Check - 189. Should have received 2 units.			

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	6/23/11 Accu Check - 183. Should have received 2 units. 6/28/11 Accu Check - 200. Should have received 2 units. 6/30/11 Accu Check - 178. Should have received 2 units. The June 2011, "Medication Record", further indicated Verapamil was given on the following two days when the blood pressure readings fell below the hold parameters and also lacked documentation of Resident # 16 receiving her scheduled Digoxin (medication used to regulate heart rates) on the following 2 days: Verapamil 6/4/11 - 106/87 6/11/11 - 128/86 Digoxin 6/5/11 6/19/11 Review of the July 1st through 20th, 2011, "Medication Record", indicated lack of sliding scale coverage for the following two days when coverage was indicated: 7/6/11 Accu Check - 204. Should have received 4 units.			

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	7/13/11 Accu Check - 191. Should have received 2 units. The July 1st through 20th, 2011, "Medication Record", further indicated Verapamil was given on the following 2 days when the blood pressure readings fell below the hold parameters: 7/9/11 - 100/50 7/16/11 - 120/62 The clinical record lacked documentation of physician notification. During interview on 7/21/11 at 2:50 P.M., LPN # 1 indicated Resident # 16 refuses sliding scale coverage and it should be charted on the MAR (Medication Administration Record). She further indicated the facility typically faxes the doctor at the end of the month to inform him/her of the refusal however the clinical record lacked documentation. 3. The clinical record for Resident # 23 reviewed on 7/21/11 at 10:55 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and hypothyroidism. The July 2011, "Physician's Orders", indicated, "...Accu Checks 4 X daily...Novolog...sliding scale before			

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	meals and at bedtime...141-160=1 units (sic); 161-180=2 units; 181-200=3 units; 201-220=4 units; 221-240=5 units; 241-260=6 units; 261-280=7 units; 281-300=8 units; 301-320=9 units; 321-340=10 units; 341-360=11 units; 361-380=12 units; 381-400=13 units; 401-420=14 units; 421-440=15 units; 441-460=16 units; 461-480=17 units; 481-500=18 units; < (less than) 100 or > (greater than) 500 call MD..." Review of the April 2011, "Medication Record", indicated incorrect sliding scale coverage for the following 7 blood sugars: 4/1/11 4:30 P.M. - 182 given 2 units. Should have received 3 units. 4/7/11 HS (bedtime) - 143 given 0 units. Should have received 1 unit. 4/10/11 4:30 P.M. - 142 given 0 units. Should have received 1 unit. 4/11/11 HS (bedtime) - 143 given 0 units. Should have received 1 unit. 4/12/11 11:30 A.M. - no Accu Check done 4/25/11 4:30 P.M. - 262 given 6 units. Should have received 7 units. 4/26/11 11:30 A.M. - 199 given 2 units. Should have received 3 units. The May 2011, "Medication Record", indicated incorrect sliding scale coverage for the following 7 blood sugars:			

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	5/1/11 HS - 141 given 0 units. Should have received 1 unit. 5/3/11 HS - 192 given 4 units. Should have received 3 units. 5/6/11 HS - 170 given 3 units. Should have received 2 units. 5/9/11 11:30 A.M. - 211 given 6 units. Should have received 4 units. 5/11/11 11:30 A.M. - 128 given 8 units. Should have received 0 units. 5/15/11 4:30 P.M. - 227 no coverage documented. Should have received 5 units. 5/15/11 HS - 199 given 2 units. Should have received 3 units. 5/24/11 4:30 P.M. - 150 given 2 units. Should have received 1 unit. 5/28/11 11:30 A.M. - no Accu Check done Review of the June 2011, "Medication Record", indicated incorrect sliding scale coverage for the following 6 blood sugars: 6/1/11 4:30 P.M. - 162- no coverage documented. Should have received 2 units. 6/1/11 HS - 161- no coverage documented. Should have received 2 units. 6/6/11 11:30 A.M. - 188 given 2 units. Should have received 3 units. 6/8/11 HS - 189 given 2 units. Should have received 3 units. 6/13/11 HS - 182 given 2 units. Should			

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	have received 3 units. 6/15/11 4:30 P.M. - 166- no coverage documented. Should have received 2 units. 6/26/11 11:30 A.M. - no Accu Check done 6/29/11 HS - no Accu Check done The July 1st through July 20th, 2011, "Medication Record", indicated incorrect sliding scale coverage for the following 3 blood sugars: 7/2/11 HS - 172 given 3 units. Should have received 2 units. 7/13/11 4:30 P.M. - 239 given 0 units. Should have received 5 units. 7/16/11 HS - 170 given 3 units. Should have received 2 units. The clinical record lacked documentation of physician notification. Interview with LPN # 1 on 7/21/11 at 2:55 P.M., she indicated she was unsure if the errors were called to the physician. She further indicated one nurse draws up the insulin doses and that dose is not checked by a second nurse to confirm accuracy of the dose. A facility policy titled, "Communication with Physicians", dated 2006, indicated, "...It is the policy of this facility to keep the residents' physicians informed			

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	regarding the residents' condition....The Community will maintain written documentation of notification of the physician(s) of a change in resident condition in the resident record...." 4. Review of Resident #C's clinical record on 7/20/11 at 12:45 p.m. indicated diagnoses of, but not limited to, senile dementia, altered mental status, and HTN (hypertension). During a record review of the "Physician's Orders" dated 4/01/11 through 4/30/11 the orders for Venlafaxine HCL ER (Effexor) 37.5 mg (used for depression) taken once daily by mouth was discontinued on 4/7/11. A new order for Venlafaxine HCL ER 75 mg to be taken once daily by mouth was started on 4/7/11. During a record review of the "Medication Record" dated 4/8/11 QMA #3 charted that Venlafaxine HCL ER 37.5 mg was given. And again on 4/8/11 LPN #4 charted that Venlafaxine HCL ER 75 mg. Total dose given on 4/8/11 was Venlafaxine HCL ER 112.5 mg. During an interview with LPN #1 on 7/20/11 at 3:00 p.m., she indicated that she was unaware the Venlafaxine HCL ER was given twice on 4/8/11. Also indicated that the nurse must have "accidentally" signed the Medication Record twice.			

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	LPN #1 was unable to show documentation that the physician was notified of the error on 4/8/11.			
R0273	(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure sanitary conditions were maintained to prevent the potential for food borne illness or contamination. This deficient practice had the potential to affect 56 of 56 residents who ate and resided in the facility. Findings include:	R0273	The apples in the serving bowl were discarded and the bowl was washed. The soup/cereal bowls and cookie sheets were re-washed an allowed to air dry.the can opener and storage shelves were cleaned.The drinking glasses were soaked to remove stains and then rewashed and allowed to air dry.The shelves in the walk-in cooler will be replaced.The refrigerator and juice dispenser were cleaned.The	08/22/2011

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	During observation of the kitchen on 7/20/11 at 11:00 A.M., while accompanied by the Dietary Supervisor, the following was observed: A large glass serving bowl containing five apples was covered with dried water spots and a build-up of a sticky substance, two stacks of soup/cereal bowls, 18 juice glasses, and three large cookie sheets were stacked and stored with water between them, the cutting blade point of the stationary can opener had a build-up of sticky substance, spice/condiments storage shelves had a moderate amount of loose particles scattered on the surface, drinking glasses were laden with a build-up of white film rendering them cloudy, the green anodized finish was worn off many of the walk-in cooler's wire shelves, the inside of one kitchen refrigerator had dried, red drippings on the back wall, the juice dispenser nozzles had a build up of dried, red, sticky substance. Review of the facility cleaning schedule for the kitchen indicated the can opener and shelves were to be cleaned daily. The inside of the ovens were to be cleaned bi-weekly. The juice machine, spice racks and coolers were to be cleaned weekly and checked for outdated foods. All major appliances were to cleaned under weekly. The July schedule indicated all of the		expired items were removed from the walk-in cooler.The quaternary solution was changed.The facility is in the process of obtaining bids for a new dish machine with a built in booster heater.In the interim, the temperature has been increased and a thermometer is placed in the dish machine during the wash and rinse cycle to monitor the temperature to ensure adequated sanitizing.The Registered Dietician will present an inservice 8/9/11 to review sanitation including proper hand washing and glove use, proper food storage, proper p.p.m. in the quaternary solution, and to cover all items noted in this report.The Dining Services Manager will attend a Serve Safe Training.The Dining Services Manager or designee will review cleaning schedules daily to ensure they are being followed.The Dining Services Manager or designee will check the quaternary solution hourly each shift to ensure proper p.p.m.The Dining Services Manager will review the cleaning schedules with the Administrator weekly on an ongoing basis. The Dining Services Manager, cooks, Administrator are responsible to monitor to ensure compliance.	

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		A. BUILDING 00 B. WING	07/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD RIDGE ASSISTED LIVING	17650 GENERATIONS DRIVE SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	above had been completed through July 20, 1011. Several opened food items were expired and remained in the walk-in cooler beyond the three day limit: A two liter bottle of ginger ale opened on 5/14/11, cocktail sauce opened 2/13/11, cottage cheese opened 6/13/11, and sour cream opened 7/14/11. The quaternary (quat) solution was tested by the Dietary Supervisor on 7/20/11 at 11:07 A.M., and indicated 50 p.p.m. (parts per milliliter). The Dietary Supervisor indicated in an interview, (at the time) the quaternary solution was dispensed automatically with the water from a faucet. He further indicated the quaternary solution should be 200 p.p.m. He indicated the solution was prepared a couple hours earlier, and needed to be replaced. The Dietary Supervisor was observed at 11:15 A.M., wiping the stove top with a dingy, gray towel he retrieved from the same 50 p.p.m. quat bucket. Observation of the automatic dishwasher machine indicated the rinse cycle failed to get up to the manufacturer's recommended temperature for sanitation. Three attempts on 7/20/11 at 11:35 A.M., by Dietary Staff #20 failed to reach a temperature of 120 degree F (Fahrenheit) recommended to			

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	properly sanitize the dishware. During observation of the same process with the Maintenance Supervisor on 7/21/11 at 10:20 A.M., the rinse cycle on the dishwasher machine registered 113 degrees F. for nine seconds. He indicated the facility dishwasher used chemical sanitation and not hot water sanitation, but it needed to reach 120 degrees F. and hold that temperature for 9 seconds. A metal stamped label attached to the dishwasher unit indicated: "Chemical (sanitation)-Rinse: 120 degrees F. for a minimum of nine seconds." During interview with the Maintenance Supervisor on 7/21/11 at 10:30 A.M., he indicated he would have the repairman out to service the dishwasher. The Maintenance Supervisor, on 7/22/11 at 11:10 A.M., indicated (as a result of the inspection by the repairman on the previous day) the dishwasher needed a "booster" to assist with bringing the water temperature to the proper sanitation level. He further indicated the booster had been ordered to make the repair. The Dietary Manager was observed on 7/20/11 at 11:15 A.M., wearing disposable gloves and then entered into the walk-in cooler to retrieve hard boiled eggs. He was then observed handling the eggs with the same pair of gloves he used			

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	to open the door of the cooler. He failed to remove the contaminated gloves, wash his hands, and replace the gloves with a new pair prior to handling the hard boiled eggs. At 12:12 P.M., on 7/20/11, the Dietary Manager was observed wearing disposable gloves and serving up lunch at the steam table. He left the table, opened the refrigerator and removed two chef salads from the refrigerator. He returned to the steam table, removed the cellophane wrap on the salads while gripping the top-side of the salad plate, and placed it on a serving tray. He failed to wash his hands and replace the contaminated gloves prior to touching the top-side of the salad plate. The Dietary Manager was also observed ladling hot soup into the soup bowls that had the water residue in them earlier. The bowls still had small pools of water on the bottom of the bowl to which he added the soup. During an interview with the Dietary Manager on 7/20/11 at 11:20 A.M., he indicated he had only been employed at the facility for five weeks. He further indicated the kitchen was in need of a deep-cleaning. This state rule substantiates Complaint IN00093337.			

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R0298	(2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, interview, and record review, the facility failed to dispose of expired medications in a timely manner. This deficient practice involved 2 of 4 medications carts and affected 5 of 55 residents whose medications were stored in the carts.	R0298	The medications for residents #7, #10, #14, #20, and #30 have been reviewed and corrected with either proper labels or destruction.Other residents who had the potential to be affected were identified through a facility audit.Items in all medication carts were inspected to ensure proper	08/15/2011

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	Resident: # 7, 10, 14, 20, 30 Findings include: During inspection of the medication carts on 7/21/11 at 10:20 A.M., accompanied by LPN # 1, the following was observed: Medication Cart # 1 Resident # 14--one Optive eye drops, no open date, dispense date 4/15/11; one Optive eye drops, no open date, dispense date 4/5/11 Resident # 10--one Nasacort nasal spray, open date 3/22/11 Resident # 20--one Ventolin inhaler, no open date, dispense date 9/28/10 No pharmacy label on inhaler to identify resident--One Ventolin inhaler, no open date Medication Cart # 2 Resident # 30--one Ventolin inhaler, no open date, dispense date 10/5/10 Interview on 7/21/11 at 10:20 A.M., with LPN # 1, she indicated the inhaler without a label belonged to Resident # 7. She		labeling, dates opened as well as discarding any expired medications.The pharmacy technician conducts an audit fo the medication carts on a monthly basis to ensure compliance.The consultant pharmacist will conduct an in-service for nurses and Q.M.A.'s to review proper lableing and disposing of medications in a timely manner.The facility has designated a staff member to conduct an audit of each medication cart at least weekly using the pharmacy-provided checklist. The desinated staff member will review the findings with the Health Services Supervisor and will correct and items noted to be deficient. These audits will be conducted on an on-going basis.The Health Services Supervisor or designee will review the information with the Administrator at least weekly.The Health Services Supervisor, Medical Records Designee, Administrator are responsible to monitor to ensure compliance.	

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	further indicated the inhaler had previously been discontinued. Interview on 7/21/11 at 10:40 A.M., LPN # 1 indicated the pharmacy checks the medication carts monthly. Review of a "(Name) Expired Medications & Timed Orders" sheet, received on 7/21/11 at 11:00 A.M., by LPN # 1, indicated the last inspection was 7/2011, no day of the month noted. A "Storage and Stabililty (sic) of Selected Medications" list, dated 02/05, received on 7/21/11 at 11:00 A.M., by LPN # 1, indicated, "...Eye Medications...need date open sticker...All other opthamics (sic)...Expiration...90 days...Nasal Sprays/Inhalers...need date open sticker...Expiration...90 days...If no date open is found then expiration is from dispensing date..."			

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R0300	(4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, interview, and record review, the facility failed to properly label medications requiring an open date, with an open date. This	R0300	The medications for residents #7, #14, #20, #26, #30 and #48 have been reviewed and corrected.Other residents who had the potential to be affected were identified through a facility audit.The pharmacy consultant will conduct an inservice 8/15/11 to review proper labeling of medications.The pharmacy technician audits the medication carts monthly to ensure medications are properly labeled including open date, and or discarded if expired.The facility will designate a staff member to audit the medication carts weekly using the pharmacy-provided checklist. These audits will be conducted on an on-going basis. The designee will review the findings with the Health Services Supervior and make any corrections necessary.The Health Services Supervisor will review the findings with the Administrator weekly.The Health Services Supervisor, Medical Records Designee, Administrator are resposible to monitor to ensure compliance.The Health Services	08/15/2011

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	deficient practice involved 3 of 4 medications carts and affected 6 of 55 residents whose medications were stored in the carts. Resident: # 7, 14, 20, 26, 30, 48 Findings include: During inspection of the medication carts on 7/21/11 at 10:20 A.M., accompanied by LPN # 1, the following was observed: Medication Cart # 1 Resident # 14--one Optive eye drops, no open date label, dispense date 4/15/11; one Optive eye drops, no open date label, dispense date 4/5/11 Resident # 20--one Ventolin inhaler, no open date label, dispense date 9/28/10 No pharmacy label on inhaler to identify resident--One Ventolin inhaler, no open date label Medication Cart # 3 Resident # 48--one Symbicort inhaler, no open date label, dispense date 6/6/11 Medication Cart # 2			

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	Resident # 26--one bottle Travatan Z 0.004 % eye drops, no open date label, dispense date 6/21/11 Resident # 30--one Ventolin inhaler, no open date label, dispense date 10/5/10 Interview on 7/21/11 at 10:20 A.M., with LPN # 1, she indicated the inhaler without a label belonged to Resident # 7. She further indicated the inhaler had previously been discontinued. Interview on 7/21/11 at 10:40 A.M., LPN # 1 indicated the pharmacy checks the medication carts monthly. Review of a "(Name) Expired Medications & Timed Orders" sheet, received on 7/21/11 at 11:00 A.M., by LPN # 1, indicated the last inspection was 7/2011, no day of the month noted. A "Storage and Stabililty (sic) of Selected Medications" list, dated 02/05, received on 7/21/11 at 11:00 A.M., by LPN # 1, indicated, "...Eye Medications...need date open sticker...All other opthamics (sic)...Expiration...90 days...Nasal Sprays/Inhalers...need date open sticker...Expiration...90 days...If no date open is found then expiration is from dispensing date... "			

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R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure the residents' clinical records were complete and documented appropriately for 2 of 7 residents reviewed for complete clinical records in a sample of 7. Residents: # 7, 46 Findings include: 1. The clinical record for Resident # 46 reviewed on 7/20/11 at 11:00 A.M., indicated diagnoses of, but not limited: diabetes mellitus, hypertension, and hyperthyroidism. The July 2011, "Physician's Orders", indicated, "...Accu Checks before meals and at HS (bedtime)...5/4/11...Novolin	R0349	The clinical records for residents #7 and #46 have been reviewed, updated and corrected if indicated.Other residents who had the potential to be affected were identified through a facility audit.An inservice will be held on 8/15/2011 for all nurses and Q.M.A.'s to review this rule and what is determined to be a complete and accurate medical record.The Health Services Supervisor or designee will review reports and forms including but not limited to: 24-hour report; medication administration records; insulin and sliding scale documentation; daily vital records to ensure that pertinent information obtained from those reports is recorded in the clinical record of each resident.These audits will be completed on a continuing basis. The Health Services Supervisor or designee will review the information	08/15/2011

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	R...sliding scale...200-250=4 units; 251-300=6 units; 301-350=8 units; 351-420=10 units...5/4/11..." Review of the May 2011, "Medication Record", indicated Accu Checks were only done at 7:30 A.M. and HS. Review of the June 2011, "Medication Record", indicated Accu Checks were only done at 7:30 A.M. and HS. It further indicated a omission of Accu Check testing on 6/22/11 Accu Check at HS. Review of the July 1st through July 19th, 2011, "Medication Record", indicated Accu Checks were only done at 7:30 A.M. and HS. A "Physician's Telephone Orders", dated 5/4/11, indicated, "...Accu Check A.C. (before meals)..." During interview on 7/21/11 at 2:55 P.M., LPN # 1 indicated she was unsure why the blood sugar times ordered by the physician were not the times on the Medication Record and unsure why the blood sugars were not done prior to all meals. 2. Review of Resident #7's clinical record on 7/20/11 at 12:45 p.m., indicated diagnoses of, but not limited to, senile		obtained with the Administrator at least weekly.The Health Services Supervisor, Medical Records Designee, Administrator are responsible to monitor to ensure compliance.	

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	dementia, altered mental status, and HTN (hypertension). During a record review of the "Physicians Orders" from 12/10/11 through 7/20/11 each stated, "...Acetaminophen 325 mg (milligram) table sic (tablet) Give 2 tablets (650 mg) orally as directed as needed for pain 12/10/10...." No frequency was indicated. During a record review of the "Physicians Orders" from 12/10/10 through 1/31/11 each stated, "...Albuterol inhaler 2 puffs Inhaulation (sic) PRN 12/23/10...." No frequency or dosage was indicated. During a record review of the "Physicians Orders" from 2/1/11 through 7/20/11 each stated, "...Ventolin HFA 90 mcg (microgram) inhaler Inhale 2 puffs by mouth as directed as needed PRN 12/23/10...." No frequency was indicated. During a review of the "Medication Record" indicated that Resident # 7 received 325 mg of Acetaminophen twice in December, once in May, and once in June. The PRN Ventolin had not been administered since Resident # 7 was admitted in December. During an interview with LPN #1 on 7/20/11 at 3:00 p.m., she indicated that all			

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	medications should have a frequency and dosage. She indicated she was unaware Resident #7 had medications that lacked frequency and dosage since 12/10/10.			
R0409	(d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure a resident had received an annual tuberculin skin test (Mantoux) after admitted to the facility for 1 of 7 residents reviewed for Mantoux testing in a sample of 7. Resident: # 46 Findings include: The clinical record for Resident # 46 reviewed on 7/20/11 at 11:00 P.M., indicated diagnoses of, but not limited: diabetes mellitus, hypertension, and hyperthyroidism. It further indicated Resident # 46 had been admitted to the facility on 4/17/10. Review of the July 2011, Physician's Orders, indicated, "...May have yearly	R0409	Other residents who had the potential to be affected were identified through a facility audit.The resident received a mantoux on 7/20/2011.Medical records are audited monthly to ensure timely administration of a yearly mantoux.The medical records checklist includes an area to monitor dates for yearly mantouxs. The medical records designee reviews the checklist the beginning of each month and provides a list of residents who are due for yearly mantouxs. The Health Services Supervisor or designee administers the mantouxs and the results are entered into the medical record.At the end of the month, the checklist is reviewed to ensure that all residents requiring a yearly mantoux received one. The Health Services Supervisor or designee, Medical Records designee are responsible to monitor to ensure compliance.	07/22/2011

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	Mantoux Due 4/11..." Resident 46's clinical record indicated she received a 1st step Mantoux on 3/22/10 and a 2nd step on 4/19/10. The clinical record lacked documentation of an annual Mantoux. During interview with the Administrator on 7/20/11 at 2:55 P.M., she indicated Resident # 46 had not received an annual Tuberculin Test. She further indicated the facility would administer it today.		Monitoring is done monthly on a continuing basis.	